Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Fiona House
Name of provider:	Praxis Care
Address of centre:	Donegal
Type of inspection:	Unannounced
Date of inspection:	05 August 2025
Centre ID:	OSV-0003924
Fieldwork ID:	MON-0047603

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

Fiona House provides full-time residential care for six people with an intellectual disability who are over the age of 18 years. This centre is located in a residential area of a busy town and a range of community amenities are nearby. Residents are supported by a team of support workers during the day. Night-time support is provided by either one or two support workers through a combination of sleep over or waking night duties which is dependent on occupancy levels and residents' assessed needs.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	2

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Tuesday 5 August 2025	16:05hrs to 20:50hrs	Úna McDermott	Lead
Wednesday 6 August 2025	09:25hrs to 11:30hrs	Úna McDermott	Lead
Tuesday 5 August 2025	16:05hrs to 20:50hrs	Stevan Orme	Support
Wednesday 6 August 2025	09:25hrs to 11:30hrs	Stevan Orme	Support

What residents told us and what inspectors observed

This was an unannounced inspection. It was conducted due to the Chief Inspector of Social Services receiving information of concern relating to the quality and safety of the care provided at this centre and to monitor compliance with the Care and Support of Residents in Designated Centres for Persons with Disabilities Regulations (2013). It was completed over two days and during this time, inspectors met with two residents, seven staff members and spoke with two separate families by telephone.

Overall, inspectors found that the registered provider had the capacity and capability to provide a good quality and safe service. While an inspection completed in May 2025 found non-compliance relating to safeguarding of residents and submission of statutory notifications, this was not the case on this inspection. The provider had taken prompt action to address the gaps found at that time and to return to compliance under these regulations. In addition, it was noted that the residents living here had a range of diverse needs, were growing older and some had changes in their family circumstances. A review of care and support arrangements found that they met with each persons individual needs in line with the statement of purpose for the service. The provider had identified concerns in relation to compatibility of resident and had taken collaborative action with their funder and the wider multi-disciplinary team to address these concerns. However, ongoing work was required to ensure that the rights of all residents to the peaceful enjoyment of their home was protected. This will be further outlined under regulation 9 later in this report.

On the first afternoon of inspection, inspectors met with the person participating in management who was present at the centre. They said that they were covering for the person in charge, who was on leave and due to return the following day.

As outlined, there were two residents at the centre. Three others were spending time with their families and one was unwell and in hospital. The inspectors noted that there were sufficient staff members on duty that day. This included a one to one staffing ratio for a resident at the centre that day and for the resident in hospital. An inspector met with both residents over the course of the two days.

One was observed moving freely around their home and garden. While they usually attended a structured day service, this was closed for a summer break which meant that the resident was at home. They spoke to the inspector about plans they had to travel to meet their family at a later date. They said that they were happy in their home and made choices about their daily life, for example, what they liked to eat. Later, they were observed eating a nutritious meal at the table which they said they enjoyed. In addition, they spoke about their neighbours and local community. They said that they liked to help to keep the area clean and tidy and to assist with picking up litter. They also said that they met with their neighbour at the weekend to attend mass and to socialise afterwards. When asked, they spoke about issues that arose with another resident on occasion. While they said they felt upset at times, they

knew how to raise a concern and if they did, they felt supported by the staff team and management.

The second resident liked to sit in the sitting room where they had a connect four game and a television. Staff were noted offering a choice of viewing options so that they could choose what they liked to watch. They had their dinner in the sitting room which was their preference and when they refused the food presented to them, this was respected and they were provided with an alternative which they accepted. While they did not hold conversations with the inspectors, they were happy to sit with them and to use some signs such as thumbs up and a wave for goodbye. The inspectors were present later in the evening when the resident was completing their bedtime routine. Staff said that this routine was important to them and inspectors were aware that safeguarding risks were most likely at this time if the resident became upset or frustrated. Inspectors overheard the resident vocalising loudly in the bathroom while preparing for bed. The staff member providing support was singing softly with the resident. Later, they were observed removing themselves quietly from the room and a different staff member provided support. Inspectors noted that this approach was considerate, caring and effective at that time. When in the inspectors were leaving, the resident presented as content, while wearing their night clothes and finalising their evening time routine.

Fiona House provided a comfortable home where the residents presented as content in most part, and where the care and support provided was of a high standard. The inspectors' findings were validated by family members spoken with, who said that they were happy with the quality of care provided. If they had a concern, they said that they were aware of what to do. One family representative spoke about this and how a concern they raised was addressed to their satisfaction.

The next two sections of this report present the findings of this inspection in relation to the governance and management arrangements in place in the centre and how these arrangements impacted on the quality and safety of the service being delivered to each resident living in the centre. Ongoing work in relation to the compatibility matters arising would further strengthen the service provided. This will be expanded on under regulation 9 in the second section of this report.

Capacity and capability

Inspectors found improvements in the centre since the May 2025 inspection. The provider demonstrated the capacity to take action to address the issues found through a enhanced monitoring plan for the centre.

While the person in charge remained new to the service, they had settled in well. The leadership presence at the centre was strengthen, llines of authority were clear and staff were aware of who to report to.

The centre was well resourced with equipment, facilities and transport which met

with the assessed needs of the resident living there. There were plenty of staff on duty and their competence was supported through a programme of training and professional development. The complaints process was working well and where matters required a statutory notification, this was completed.

Matters relating to the compatibility of residents relating to their changing needs will be outlined in the quality and safety section of this report.

Regulation 16: Training and staff development

Staff had access to a range of training opportunities as part of a programme of professional development. This included both online and in-person training. This meant that residents were supported by competent staff who were trained in areas relating to individual needs.

All staff had completed training in safeguarding and protection. Following the May 2025 inspection, the provider took further action to enhance staff knowledge in this area. For example, two bespoke in-person training days were arranged for later this month. This meant that staff would have an opportunity to complete off site training in order to enhance their skills and knowledge in this area.

Where staff expressed interest in individual training as part of their professional development, this was supported through the provider's appraisal process. An inspector reviewed the minutes of one meeting and found that additional leadership training was offered to staff if requested.

In addition, the person in charge developed a staff supervision schedule following the last inspection. A sample of five staff files were reviewed. This review found all five were provided with regular one to one supervision meetings and records of the meetings were documented. This meant that structured opportunities to meet with their line manager was provided, where professional goals were discussed or concerns could be raised. Staff spoken with told the inspector that they found this process supportive.

Judgment: Compliant

Regulation 23: Governance and management

The inspector found improvements in the leadership arrangements and a strengthening of management systems since the May 2025 inspection. This was evidenced by the fact that the provider took prompt action in relation to the gaps found at this time, in order to address the matters arising and to improve the safeguarding and protection systems for residents living at Fiona House.

Inspector found a consistent leadership presence at the centre as on first day of inspection when the person participating in management was present as the person in charge was on leave. This structure was sustained out of hours and at weekends by team leaders employed at the centre and individual keyworkers who supported residents. Staff spoken with told inspectors that the regular leadership presence at the centre enhanced the quality of the service.

At provider level, additional planned and unplanned visits to the service were completed by senior management in order to provide support to the local management team and to complete audits of the quality of the service.

Support meetings were held with the staff team in relation cultural governance matters arising which the provider was aware of and were working to resolve in line with organisational policy. A review of staff support systems found that ample opportunities for staff to raise concerns was provided to both core staff members and consistent agency staff. This included informal discussions with line management, formal team meetings, and individual appraisal meetings and staff supervision meetings. When asked, staff told the inspectors that the person in charge was approachable and supportive.

Safeguarding systems were enhanced. For example, the person in charge showed an inspector a quality improvement action plan which had specific time based actions identified which were already completed, or to be completed by the staff member responsible. These actions will be expanded on under regulation 8 in this report.

There were concerns relating to interpersonal compatibility at this centre which meant that residents were at risk of psychological abuse by their peers. There was an upward trend in the frequency and intensity of incidents recently which the provider was aware of. In response, they adopted a collaborative approach which included consultation with the local safeguarding officers and meetings with the Health Service Executive (10 July 2025) and members of the residents' multi-disciplinary teams. In addition, compatibility risk assessments were completed (9 April 2025 and 30 July 2025) which were subject to regular review.

However, while prompt action was taken and the provider's response was ongoing at the time of inspection, it was not resolved and further work was required. Inspectors found that while residents expressed compassion towards their peers, the increase in behaviours incidents impacted on them from time to time. This will be addressed under Regulation 9 in this report.

Judgment: Compliant

Regulation 31: Notification of incidents

An inspector reviewed the incidents arising in the centre from 1 June 2025 to 6 May 2025. All notifiable information was submitted for the attention of the Chief

Inspector of Social Services in line with the requirements of this regulation.

Judgment: Compliant

Regulation 34: Complaints procedure

Inspectors were assured that the provider had effective complaints management systems in place at Fiona House. This meant that residents were supported to raise concerns about the quality of the service if they wished to do so.

Information on how to make a complaint was available in easy to read format for residents use and prominently displayed on a notice board in the communal area. The name and contact details for the complaints office was also provided along with their picture. In addition, information on advocacy services was available if required.

A resident told inspectors that they were aware of how to raise a concern and said that they had done so in the past. A review of the minutes of residents' weekly team meetings found that the complaints process was a standing agenda item. In addition, family members were aware of how to make complaints and were satisfied that issues they raised were dealt with appropriately.

A review of documented complaints found that residents were supported to make 14 complaints between 25 June 2025 and 19 July 2024. In the main, the complaints made related to compatibility issues between residents at the centre. An inspector reviewed a sample of four complaints and found that they were addressed in line with the provider's policy. There were no open complaints at the time of inspection.

Judgment: Compliant

Quality and safety

While the work of the provider in relation to compatibility issues arising was prompt and responsive, it required ongoing work to reach compliance under Regulation 9 below. This was due to the ongoing impact on the rights of residents to have peaceful enjoyment of their home and to access all areas in line with their wishes.

The provider had risk management systems in place and access to a positive behaviour support specialist. While there was an increase in the frequency of safeguarding incidents at the centre, a review completed by the inspector found that they were addressed in line with local and national safeguarding policy.

Regulation 26: Risk management procedures

The provider had systems in place for the identification, assessment and management of risks arising at the centre. This included a risk management policy which was up to date. This enhanced the quality of the service provided to residents.

A review of the centre's risk register completed by an inspector found that it provided an accurate reflection of risks arising at the centre. This included risks relating to behaviours of concern

Residents had individual risk assessments which were up to date and subject to regular review. Some residents at this centre were at risk of making false allegations as documented on safeguarding screening forms. A risk assessment to address this was updated on 30 July 2025 in response to identification of this issue. Control measures were appropriate to the risk and the risk rating was in line with the provider's risk measurement tool.

Positive risk taking was promoted at the centre and activities such as using a local swimming pool or use of laundry facilities and products were risk assessed in order to ensure that safety was prioritised if required.

Judgment: Compliant

Regulation 7: Positive behavioural support

The person in charge ensured that residents who required support with behaviours of concern had access to a positive behaviour support specialist who had a regular presence at the centre in order to provide support to the residents and the staff team.

The positive behaviour support policy was up to date and all staff had access to training.

An inspector reviewed two positive behaviour support plans and found that they were updated following the May 2025 inspection. This meant that guidance for staff was current and appropriate to residents' behaviour support needs. The updates were due for review and agreement by the behaviour support specialist.

Staff spoken with were aware of the behavioural issues arising at the centre, of when they might arise and of what to do if required. As outlined in the opening section of the report, inspector observed staff responding calmly on the first day of inspection and supporting a resident to return to baseline after a period of upset and frustration. In addition, staff were aware of how to support a second resident who could become upset at times. Their behaviour support plan recommended that

they have one to one attention and that this could be provided through a walk with staff in the evening time. The inspector saw that this was documented in their daily notes which meant that recommendations were followed.

The provider promoted a restriction free environment. A review of the use of the kitchen found that while restrictions were there in the past they were no longer used and residents had access to drinks and refreshments. However, at times they were supported to choose hot milk instead of tea in order to help with sleep at night-time.

Judgment: Compliant

Regulation 8: Protection

Inspectors found improvements in safeguarding arrangements at the centre since the last inspection (May 2025). The provider and the leadership team had taken significant action to address safeguarding concerns and to return to compliance since this time. This reduced the risks posed to residents living at the centre.

All safeguarding matters were acknowledged as such. They were documented, screened and submitted for the review of the safeguarding and protection team if required. Interim safeguarding plans were put in place promptly and information to guide staff was provided. Those spoken it were clear on what to do if required.

Additional safeguarding audits were completed at the centre. These included announced and unannounced visits by members of the senior management team and the provider's safeguarding champion. Additional auditing tools were introduced to the centre such as a new safeguarding log and inclusion of safeguarding on the shift handover book.

In addition, enhanced training opportunities were planned for staff and due to take place during the month of the inspection (August 2025). This included two bespoke face to face training days which were due to be held off site in order support staffs' understanding of the importance of safeguarding for all.

Written guidance in the form of information on the safeguarding process was available on the residents and staff notice boards. A photograph and contact details of the designated officer were displayed. When asked, staff were aware of what to do and of how to escalate a safeguarding concern if required.

Judgment: Compliant

Regulation 9: Residents' rights

In the main, the provider had arrangements in place to ensure that a person centred

service was provided to the residents living at Fiona House which respected their human rights. However, ongoing work was required in order to ensure that all residents had peaceful enjoyment of their home and the freedom to access all rooms in their house as they wished.

Rights promoting activities at the centre included weekly residents' meetings where residents made choices about their day to day lives at the centre. If residents did not wish to engage in pre-planned activities their right to decline was respected. A review of the roster completed by an inspector found that staff were available at the centre during the day to provide support for those who preferred to stay at home. For example, two residents were noted to attend their day centre in line with their wishes or to remain at home if they preferred.

Residents were supported to understand how to raise concerns and to raise complaints.This was documented on statutory notifications submitted to the Chief Inspector and on incident reports. Inspectors found that a number of complaints were made which related to times when residents became upset due to the noise levels and negative atmosphere in their home.

As outlined throughout this report, the provider was managing complex interpersonal compatibility issues at the centre which were linked to a decline in a resident's health and a change in their personal circumstances. This impacted on the residents living at Fiona House as they were described as anxious about their peers behaviour, would go to their rooms and did not have free access to all areas of their home if the other resident was present.

The provider was aware of this impact and had put a number of actions in place such as one to one staff supports, risk assessments and behaviour support guidance. In addition, they were working with the Health Service Executive (HSE) to assess the living requirements for all residents. However, at the time of inspection this was an ongoing situation and not yet resolved. While the actions taken showed that they were responsive to the situation further work was required in order to reach full resolution.

Judgment: Substantially compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 16: Training and staff development	Compliant
Regulation 23: Governance and management	Compliant
Regulation 31: Notification of incidents	Compliant
Regulation 34: Complaints procedure	Compliant
Quality and safety	
Regulation 26: Risk management procedures	Compliant
Regulation 7: Positive behavioural support	Compliant
Regulation 8: Protection	Compliant
Regulation 9: Residents' rights	Substantially compliant

Compliance Plan for Fiona House OSV-0003924

Inspection ID: MON-0047603

Date of inspection: 05/08/2025

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	Judgment
Regulation 9: Residents' rights	Substantially Compliant

Outline how you are going to come into compliance with Regulation 9: Residents' rights:

The registered provider is currently managing the compatibility concerns through resident's personal plans and agreed safeguarding plans. The Registered Provider will ensure plans are reviewed monthly for effectiveness. Commenced 11/09/2025.

The registered provider has escalated compatibility concerns with the statutory provider. The registered provider and statutory provider are in consultation regarding future plans for the centre to reduce compatibility concerns. To be completed by 30/06/2026.

The registered provider will review compatibility risk assessments at a minimum of 3 monthly to ensure residents rights are reviewed. To be completed by 30/12/2025.

The registered provider has a restrictive practice register which ensures restrictions are least restrictive and in the best interest of residents. The Person in Charge will review impact of restrictive practices on residents in restrictive practice committee. To be completed by 31/10/2025.

The Person in Charge will ensure that resident's rights are discussed in residents meetings and resident's key working. Commenced 01/09/2025.

The Registered Provider will ensure that the Positive Behaviour Support Therapist provides support at a minimum of bi monthly in the centre, to include reviews of positive behavior support plans, incident management and safeguarding plans. Commenced 01/09/2025.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 09(2)(b)	The registered provider shall ensure that each resident, in accordance with his or her wishes, age and the nature of his or her disability has the freedom to exercise choice and control in his or her daily life.	Substantially Compliant	Yellow	30/06/2026